**CFRA Employee Request for Third Opinion with Workers’ Compensation (CAA2212)**

Send Certified And Regular Mail

Certification # \_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

NAME

ADDRESS

Dear NAME:

We have received your request on DATE for a third opinion regarding the following California Family Rights Act (CFRA) medical certificate received on (DATE), dated DATE:

* LIST RELEVANT INFORMATION

**This issue is unrelated to any of your rights or benefits under the Workers’ Compensation regulations.**

You agree to provide a list of three Health Care Provider names by DATE [WITHIN 7 DAYS OF THE DATE OF THIS LETTER]. If you do not provide this list, the COMPANY will send you a list of three providers to choose from.

**The third Health Care Provider must be designated or approved jointly by COMPANY and the employee**. The employer and the employee must each act in good faith to attempt to reach agreement on who to select for the third opinion provider.

Once the Health Care Provider has been chosen, it will be your responsibility to contact her or him and scheduled an appointment. You must provide the Health Care Provider a release to review the previous medical documentation necessary to complete the opinion.

COMPANY is responsible for the cost of the visit and any fees associated with filling out the medical certificate. COMPANY is not responsible for time for travel or time spent at the appointment however, we will pay for reasonable out of pocket expenses upon your submission of appropriate receipts.

This third opinion shall be final and binding.

**Failure to participate in the third opinion appointment may result in COMPANY using the second opinion medical certificate dated DATE for your CFRA needs.**

**Please remember you are solely responsible for providing on-going medical certificates indicating your need for a medical leave of absence until such time your Workers’ Compensation claim has closed.** Your current medical certificate expires on DATE.

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If you have any questions about the family and medical leave or other benefits, please contact:

Name: CONTACT NAME AND TITLE

Phone: CONTACT INFORMATION

Enclosures:

1. California Family Rights Act (CFRA) Medical Certification form [BLANK]
2. California Family Rights Act (CFRA) Medical Certification form [Health Care Provider Second Opinion]
3. California Family Rights pamphlet
4. California Family Rights Act (CFRA) Medical Certification form DATE [LIST ALL IF MULTIPLE]
5. Job Description [Title of Job Description]
6. Authorization for Release of Medical Information [IF NOT ALREADY OBTAINED]